DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2011 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155191		(X2) M A. BUII B. WIN	LDING G	01	(X3) DATE COMPI 06/02/2	LETED
	PROVIDER OR SUPPLIER			2210 G	ADDRESS, CITY, STATE, ZIP CODE REENTREE NORTH (SVILLE, IN47129		
(X4) ID PREFIX TAG K0000	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
I A DOD ATOM	State Licensure State Indiana State accordance with Survey Date: 06 Facility Number: Provider Number AIM Number: 1 Surveyor: Mark Specialist At this Life Safe Westminster Heafound not in come Requirements for Medicare/M	r: 155191 00266130 Bugni, Life Safety Code ty Code survey, lith Care Center was apliance with r Participation in aid, 42 CFR Subpart afety from Fire and the the National Fire iation (NFPA) 101, Life C) and 410 IAC 16.2. ding was surveyed with ting Health Care cility was determined to 1) construction and fully are is no fire separation inal building and the new tym because the original		0000	RE: ID DTB621Provider Number: 155191 Facility Nu 000100 AIM Number: 1002 June 22nd, 2011 Kim Rhode Director Long Term Care Ind State Department of Health North Meridian, Section 4-B Indianapolis, In 46204 Dear Rhodes Please find Forms CMS-2567 with the plan of correction for the deficiencies sited during our recertification Indiana State Licensure Sur conducted at Westminster F Care Center on June 2nd, 2 can be reached at 812-282- ext 123 if you would have an question or comments regan the ISDH Survey Report System documents. Sincerely, Floyor Shewmaker Administrator Westminster Health Care Co	66130 es, diana 2 Ms. Ms. es on and vey dealth 011. I 9691 ery ding stem d	(V6) DATE
LABORATOR	Y DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DTB621

Facility ID:

000100

AND PLAN OF CORRECTION IDENTIFICATION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155191	A. BUIL	DING	NSTRUCTION 01	(X3) DATE S COMPL 06/02/2 (ETED
	ROVIDER OR SUPPLIER		B. WING	STREET A	DDRESS, CITY, STATE, ZIP CODE	00/02/2	
WESTMII	NSTER HEALTH CA	ARE CENTER		CLARKS	SVILLE, IN47129		
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K0143 SS=E	the same construct has a fire alarm sidetection in the coto the corridors. capacity of 94 and the healthcare potime of this visit. Quality Review by Figure Safety Code Special 06/09/11. The facility was found aforementioned regular evidenced by the following the following aforementioned regular evidenced by the following aforementioned regular evidenced by the following the following at the following at the following and the following and the following and following and following and following and following and the following and following and the following and followi	Robert Booher, REHS, Life ist-Medical Surveyor on and not in compliance with the alatory requirements as lowing any portion of a facility re housed, examined, or ation of a fire barrier of e construction; is mechanically ventilated, as ceramic or concrete ed with signs indicating that turring, and that smoking in a is not permitted in IFPA 99 and the Association. 8.6.2.5.2 ation and interview, the ensure 1 of 1 oxygen	K0	143	K 143 What Corrective actio will be accomplished for the residents found to have been affected by the deficient pract No residents were affected the exhaust fan not working	tice:	07/02/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155191		A. BUII	LDING	NSTRUCTION 01	(X3) DATE S COMPL 06/02/2	ETED	
		155191	B. WIN			00/02/2	011
NAME OF I	PROVIDER OR SUPPLIEF	₹			DDRESS, CITY, STATE, ZIP CODE		
WESTMI	INSTER HEALTH C	ARE CENTER		1	REENTREE NORTH SVILLE, IN47129		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	12:10 p.m., the I storage room who sygen containe electric ceiling e working. This w				the oxygen storage room of the ICF hall. How other reside having the potential to be affected by the same deficient practice be identified and what correct action(s) will be taken: All residents on the ICF hall had the potential to be affected the deficient practice. The exhaust fan was repaired of day of Survey 6/2/11. What measures will be put into plan what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance staff will perform weekly audit of Oxygen storage closet(s) to assure exhaust fans are working properly to assure adequate ventilation. any noted performance issues will be corrected immediately by maintenance staff. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., who quality assurance program we put into place; and by what do the systemic changes will be completed. Maintenance Director of designee will report month the Quality Assurance Meeting the results of the weekly audit the Oxygen storage closet(s) regarding the operation of exhaust fans to assure that the alleged deficient practice does not recur. Any revisions or changes needed will be revised by the Quality Assurance	lents lected lected le will letive ve by n ce or lectent letive the cient letive ci	

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01			COMPLE	TED	
		155191	B. WIN			06/02/20	11	
			D. (111)		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
NAME OF I	PROVIDER OR SUPPLIER				REENTREE NORTH			
WESTMI	NSTER HEALTH CA	ARE CENTER			SVILLE, IN47129			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
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T701.44	Comparatore are in-	ana ata du wa aliku ana d			Committee, Administrator an Maintenance Director. The completion date is 7/2/11	d		
K0144 SS=F		spected weekly and add for 30 minutes per nice with NFPA 99.						
	Based on obse	rvation and interview,	K()144			07/02/2011	
		d to ensure 1 of 1			K 144			
	· ·	nerators with over 100			Whatt Correcttve actto(s) wi	ill		
		s equipped with a			be accomplished fior tthe			
	remote manual	stop. LSC 7.9.2.3			residentts fiound tto have be	en		
	requires emerg	ency generators			afiectted by tthe deficientt			
	providing powe	r to emergency lighting			practtce:			
	systems shall b	e installed, tested and			No residentis were afectied	bv		
	maintained in a	ccordance with NFPA			tihe lack of a provision for	-,		
		or Emergency and			shuting down tihe engine of	F		
		ndby Power Systems. NFPA 110,			tihe emergency generation			
		-5.5.6 requires Level I			from a remotie location			
		all have a remote						
		ation of a type similar			How otther residentts having	g		
	_	s station located			tthe pottenttal tto be affected	- I		
		m housing the prime			tthe same deficientt practice	-		
		37, Standard for the			will be identified and whatt			
	Combustion En	Use of Stationary			correcttve actton(s) will be			
		Edition, at 8-2.2(c)			ttaken			
		es of 100 horsepower			llaken			
		rovision for shutting			All as ald a sale beautiful.			
	-	e at the engine and			All residentis have tihe			
	_	ocation. This deficient			potiential tio be afectied by			
		affect all residents.			tihe lack of a provision for			
	practice could a	ancet an residents.			shuting down tihe engine of	ř		
	Findings includ	e·			tihe emergency generatior			
		.			from a remotie location A			
	Based on obse	rvation of the			manual shutiof switich tio ti	ihe		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER (X4) ID SUMMARY STATEMENT OF DETICIENCIES (EACH DEFICIENCY MIST BE PERCEDED BY FELL. TAG (EACH DEFICIENCY MIST BE PERCEDED BY FELL at 10:20 a.m., the generator set nameplate rating failed to indicate the horsepower rating of the generator set and the generator with the maintenance supervisor on 06/02/11 at 9:45 a.m., the emergency generator with the maintenance supervisor on 06/02/11 at 9:45 a.m., the emergency generator set is a four hundred kilowatt diesel generator and is well over one hundred horsepower. 3-1.19(b) SIMMARY STATEMENT OF DETICIENCIES (CITX, STATE, ZIP CODE 22 10 GREENTREE NORTH (CLARKSVILLE, INA7129) DATE PROVIDERS PLANG CORRECTION (CX5) (COMPLETT) (COMPLET	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155191		LDING	NSTRUCTION 01	(X3) DATE SURVEY COMPLETED 06/02/2011	
CLARKSVILLE, IN47129 CLARKSVILLE, IN47129 CX3) CX9	NAME OF I	PROVIDER OR SUPPLIEF	!	 1		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) emergency generator with the maintenance supervisor on 06/02/11 at 10:20 a.m., the generator set nameplate rating failed to indicate the horsepower rating of the generator set and the generator was not equipped with a remote manual stop switch. Based on an interview with the maintenance supervisor on 06/02/11 at 9:45 a.m., the emergency generator set is a four hundred kilowatt diesel generator and is well over one hundred horsepower. 3-1.19(b) PREFIX TAG CROSS-REFIGENCE COMPLETO CROSS	WESTMINSTER HEALTH CARE CENTER			1		
maintenance supervisor on 06/02/11 at 10:20 a.m., the generator set nameplate rating failed to indicate the horsepower rating of the generator set and the generator was not equipped with a remote manual stop switch. Based on an interview with the maintenance supervisor on 06/02/11 at 9:45 a.m., the emergency generator set is a four hundred kilowatt diesel generator and is well over one hundred horsepower. 3-1.19(b) Whatt measures will be putt into place or whatt systemic changes will be made tto ensure tthat the deficient practice does not recur A manual shutiof switich tio tithe emergency generatior will be in-serviced by 7/2/11. Tregarding the location and operation of tithe manual shutiof switich tio tithe emergency generatior by 7/2/11. Staf will be in-serviced by 7/2/11 regarding the location and operation of tithe manual shutiof switich tio tithe emergency generatior How the corrective actto(s) will be monittored tto ensure	PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	COMPLETION
	PREFIX	emergency ger maintenance s at 10:20 a.m., f nameplate ratir horsepower ratiset and the ger equipped with switch. Based the maintenance o6/02/11 at 9:4 generator set is kilowatt diesel over one hundi	nerator with the upervisor on 06/02/11 the generator set ng failed to indicate the ting of the generator merator was not a remote manual stop on an interview with ce supervisor on 05 a.m., the emergency is a four hundred generator and is well	PREFIX	emergency generation will be instialled ati a remotie location and tihe operation of tihe manual shutiof switich tich emergency generatior will be putt intto place or whatt systemic changes will be made tto ensure thatt the deficient practice does not recur A manual shutiof switich tich tihe emergency generatior will be instialled ati a remotie location from tihe generation when the emergency generation when the emergency generation when the emergency generation when the emergency generation when the generation of the generation of the manual shutiof switich tich tick the emergency generation and operation of tihe manual shutiof switich tick tihe emergency generation and operation of tihe manual shutiof switich tick tihe emergency generation. How the corrective actto(s)	e ion l on vill vill vir
recur, i.e., whatt qualitty assurance program will be putt intto place and by whatt datte					recur, i.e., whatt qualitty assurance program will be p	utt

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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ΔΝΟ ΡΙ ΔΝ Ο	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MU	JETIPLE CON		(X3) DATE SURVEY COMPLETED	
ANDILANO	or connection	155101	A. BUIL		01	06/02/2	
		133131	B. WINC	_		00/02/2	011
NAME OF PE	ROVIDER OR SUPPLIER	L			DDRESS, CITY, STATE, ZIP CODE		
WESTMIN	ISTER HEALTH C	ARE CENTER	2210 GREENTREE NORTH CLARKSVILLE, IN47129				
			igwdown				(V5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
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					tthe systtemic changes will b	e	
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					mainttenance sttafi tto assur	e	
					proper fiuncttoning ofi tthe		
					swittch Any revisions or		
					changes needed will be		
					reviewed by tthe Qualitty		
					Assurance Committee,		
					Administtrattor and		
					Mainttenance Directtor		
					The completton datte is 7/2/1	.1	
K0000							
-10000							
	A Life Safety Co	ode Recertification	K0	000	RE: ID DTB621Provider		
	Survey was con	ducted by the			Number: 155191 Facility Nur 000100 AIM Number: 10026		
	Indiana State D	epartment of			June 22nd, 2011 Kim Rhodes		
	Health in acco	rdance with 42 CFR			Director Long Term Care Indi		
	483.70(a).				State Department of Health 2	2	
					North Meridian, Section 4-B Indianapolis, In 46204 Dear I	√ls.	
	Survey Date: 0	6/02/11			Rhodes Please find Forms		
					CMS-2567 with the plan of		
	Facility Numbe	r: 000100			correction for the deficiencies	3	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DTB621 Facility ID:

y ID: 000100

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
AND PLAIN	OF CORRECTION	155191		LDING	02	06/02/2	
		100101	B. WIN	STREET ADDRESS, CITY, STATE, ZIP CODE			
NAME OF	PROVIDER OR SUPPLIEI	2		1	REENTREE NORTH		
WESTM	INSTER HEALTH C	ARE CENTER		1	SVILLE, IN47129		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG			DATE
	Provider Number: 155191				sited during our recertificatio Indiana State Licensure Surv		
	AIM Number: 100266130				conducted at Westminster H	•	
					Care Center on June 2nd, 20	011. I	
	Surveyor: Mark	Bugni, Life Safety			can be reached at 812-282-9		
	Code Specialis	t			ext 123 if you would have an question or comments regard	•	
					the ISDH Survey Report Sys		
	At this Life Saf	ety Code Survey,			documents. Sincerely, Floyd		
	Westminster H	ealth Care Center			Shewmaker Administrator		
	was found not	t in compliance with			Westminster Health Care Ce	nter	
	Requirements for Participation in Medicare/Medicaid, 42 CFR						
	Subpart 483.70(a), Life Safety						
	from Fire, the	2000 edition of					
	NFPA (National	Fire Protection					
	Association) 10	01, LSC (Life Safety					
	Code) and 410	IAC 16.2. The					
	2009 Rehabilit	ation Gym was					
	1	Chapter 18, New					
	Health Care Oc	•					
	This 2000	Secondary of the Control of the Cont					
		ition to the one					
	1 .	as determined to be					
	1) construction and					
	1	klered. The facility					
	has a fire alarn	=					
		on in the corridors,					
	1 '	the corridors, and					
	1	eping rooms. The					
	I	capacity for 99 and					
		of 82 at the time of					
	this survey.						
	The facility was for	and not in compliance with the					
	1	ulatory requirements as					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 02 COMPLETE			ETED	
		155191	B. WIN			06/02/2	011
			b. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				REENTREE NORTH		
\\/EQT\/II	NSTER HEALTH CA	ADE CENTED		l	SVILLE, IN47129		
WESTIVIII	NOTER HEALTH CA	ARE CENTER		CLARK	3VILLE, IN47 129		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	evidenced by the following						
K0144 SS=F	Generators are insexercised under lomonth in accordar 3.4.4.1. Based on obsethe facility failed emergency genhorsepower waremote manual requires emerging providing powers systems shall be maintained in a 110, Standard for Standby Power 1999 edition, 3-installations shamanual stop state to a break-glassioutside the roomover. NFPA 3 Installation and Combustion En Turbines, 1998 requires engine or more have prodown the engine from a remote I	spected weekly and add for 30 minutes per ace with NFPA 99. rvation and interview, do to ensure 1 of 1 merators with over 100 sequipped with a stop. LSC 7.9.2.3 ency generators or to emergency lighting the installed, tested and accordance with NFPA for Emergency and a Systems. NFPA 110, 1-5.5.6 requires Level I call have a remote action of a type similar as station located on housing the prime 137, Standard for the 138 Use of Stationary agines and Gas Edition, at 8-2.2(c) as of 100 horsepower rovision for shutting the at the engine and ocation. This deficient affect all residents.	KO	0144	K 144 Whatt Correcttve actto(s) will be accomplished fior the residentts fiound tto have be affectted by the deficient practtce: No residentis were afectied tihe lack of a provision for shuting down tihe engine of tihe emergency generation from a remotie location How otther residentts having the pottenttal tto be affected the same deficient practice will be identified and whatt correcttve acttor(s) will be ttaken All residentis have tihe potiential tio be afectied by tihe lack of a provision for shuting down tihe engine of tihe emergency generation from a remotie location A	by ded by	07/02/2011
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155101	A. BUILD		02	COMPL	ETED
		155191	B. WING			06/02/2	U11
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE REENTREE NORTH		
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		nerator with the upervisor on 06/02/11 he generator set			instialled ati a remotie locate by 7/2/11. Facility stiaf wil be in-serviced on tihe locati	I	
		ng failed to indicate the			and tihe operation of tihe	J.,	
	•	ing of the generator			manual shutiof switich for		
	set and the ger				tihe emergency generatior l	ру	
		a remote manual stop			7/2/11.		
	the maintenance 06/02/11 at 9:4: generator set is kilowatt diesel (on an interview with the supervisor on 5 a.m., the emergency a four hundred generator and is well and horsepower.			Whatt measures will be putt intto place or whatt systtem changes will be made to ensure thatt the deficient practice does nott recur A manual shutiof switich tic tihe emergency generation be instialled ati a remotie location from tihe generation by 7/2/11. Stiaf will be in-serviced by 7/2/11 regarding tihe location and operation of tihe manual shutiof switich tio tihe emergency generation. How the corrective actto(s)	o will or	
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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			02	COMPI	LETED
		155191	1	LDING		06/02/2	2011
			B. WIN				
NAME OF I	NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
MECTANINOTED HEALTH CARE CENTED					REENTREE NORTH		
WESTMINSTER HEALTH CARE CENTER				CLARK	SVILLE, IN47129		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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					changes needed will be		
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					Mainttenance Directtor		
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DTB621

Facility ID: 000100

If continuation sheet

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